

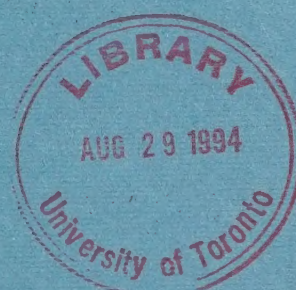
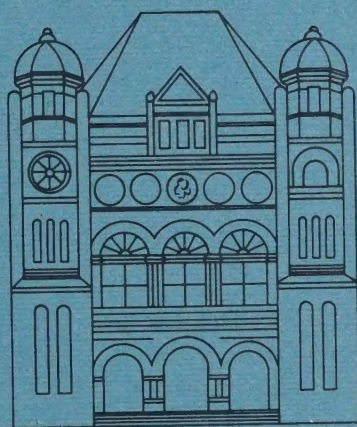
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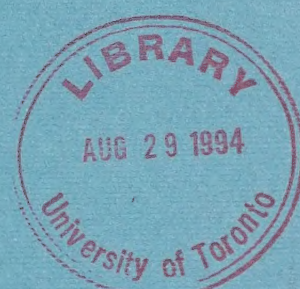
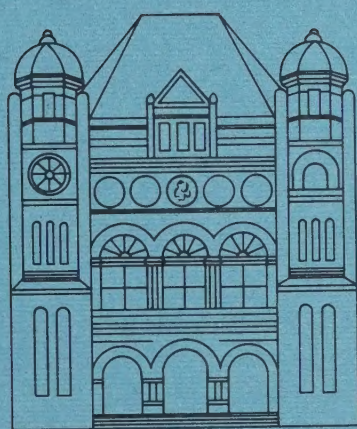


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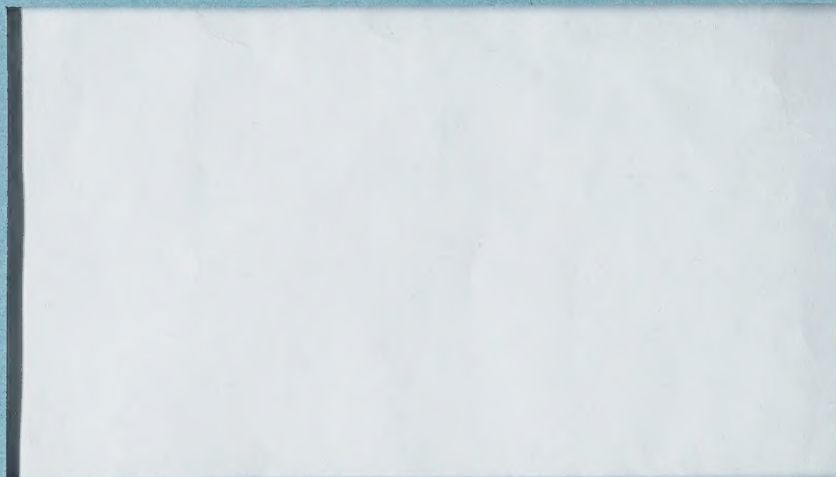
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HEALTH REFORMS IN OREGON: IDEAS FOR COST CONTROL IN CANADA?

Current Issue Paper 132

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INTRODUCTION

The state of Oregon has developed a unique and inventive model to deal with two of the most obvious shortcomings of the American health care system: rapidly rising costs and grossly inequitable access to health care. The plan, embodied in several pieces of state legislation, is designed to cover a defined range of medical services for the whole population; under the current system, some poor people get all medically indicated treatment covered by public insurance while many others have no health insurance whatsoever. The list of conditions and their treatments was developed after extensive public consultation; the procedures were ranked in order of priority; and the state was to cover as many of these procedures as it could afford, in the priorities developed during the consultation process. The proposal was halted by the federal government in August 1992, when it refused to continue to share funding for Medicaid under the new system; the necessary waivers were, however, granted by the new federal administration in March 1993.

This paper explores some of the pros and cons of Oregon's proposal and discusses elements which may be usefully examined here in Canada.

Health Care Crisis in the U.S.

Neither Americans nor Canadians need reminding of the crisis in health care in the United States.

- The U.S. spends 12.4% of its Gross Domestic Product on health care, a far higher proportion than any other developed country.¹
- 39 million Americans (of a 1985 population of 241 million) have no health care insurance.²
- Expensive high-technology procedures are overused: there are more than 20 times as many open-heart surgery units in the U.S. as in Canada, based on population, and more than 70 times as many magnetic resonance imaging units.³ A study found that as many as a quarter of coronary angiography studies and 66% of carotid endarterectomies were performed for "inappropriate reasons."⁴

- The effects of limited availability of preventive care are seen in poorer U.S. health outcomes: the U.S. has the highest rate of infant mortality of the developed countries, and the lowest male life expectancy.⁵
- Among Canadian, American and British people surveyed for one study, Americans are the least happy with their health care system; 89% in one survey think it needs fundamental change.⁶

A lack of insurance does not necessarily mean that people are denied emergency care; hospitals spend more than eight billion dollars a year providing charity care.⁷

However, it does mean that many people cannot afford routine and preventive care, with potentially devastating implications. A recent study demonstrated that women without insurance or with public insurance (Medicaid) were more likely to be diagnosed at a later stage of breast cancer, and were much more likely to die of the disease than women who had private insurance.⁸

Oregon's Fiscal Position and the Existing Health Care System

This crisis is felt in Oregon as in other states. However, the immediate context of these reforms is a catastrophic drop in the tax revenues available to the state. In November 1990, Oregon voters endorsed Ballot Measure 5, which limited property taxes, traditionally used to finance education. This means that larger proportions of general revenue must be used on education, with correspondingly less for other state services, including Medicaid.⁹

Historically, however, the state has had a relatively serious commitment to programs for the poor, and this commitment can be seen in recent initiatives. Of the three programs which received increased funding in the 1991 session of the Oregon Legislature, one was the Health Plan; the other two were low-income housing and an expansion of Headstart, the educational program for low-income children.¹⁰

The health insurance system as it exists in Oregon, as elsewhere in the U.S., is a patchwork of categorical public coverage and incomplete private coverage. Groups covered by public insurance include:

- families receiving AFDC (Aid to Families with Dependent Children, the major American welfare program); the income threshold for receiving AFDC in Oregon is \$440/month (half the federal poverty line of \$880/month) for a family of three (1990 figures);
- pregnant women and children under six if their income is less than 133% of the federal poverty line;
- children who fit into certain other categories (born after 1983 in poor families, in care, etc.); and
- aged, blind and disabled people receiving Supplemental Social Security.¹¹

People not covered, many of whom cannot afford to purchase private insurance, include many of the working poor, single people, childless families or families where the children do not fit into any of the covered categories. Approximately 200,000 Oregonians are eligible for health insurance under Medicaid, but 450,000 people in the state do not have health insurance at all, and 120,000 of these have incomes under the federal poverty line.¹² Nationally, Medicaid covers only 41% of people below the poverty line.¹³

Process of Consultation

One of the most interesting aspects of the plan was the way in which it was developed. A Health Services Commission was established and started its work in September 1989. It developed a list of 709 "condition-treatment pairs" (CT pairs), which were intended to describe all possible medical conditions and their usual treatments. It held 12 public hearings and attended 47 community meetings. It also commissioned a random telephone survey of Oregonians. The public input was intended to establish "social health values," the priorities people have for health care.¹⁴

In May 1990 the Commission released a draft "priority list" of CT pairs. They were ordered according to the health priorities Oregonians had expressed in the series of consultations and according to the results of a complicated formula which tried to quantify and calculate the costs, health outcomes and benefits of each procedure. This

list was not received very well - some of its rankings violated common sense, such as placing tooth capping just above surgery for ectopic pregnancy.¹⁵ Nonetheless, advocates of this general approach claimed that at least some of these counter-intuitive rankings came about because the Commission concentrated on immediate costs and benefits, which led to an overemphasis on low-cost procedures, and did not extend its analyses of costs and health outcomes far enough into the future.¹⁶ In response to criticism, the Commission abandoned considerations of cost in giving the CT pairs priority rankings and instead grouped them into categories based on benefit to the individual and to society, taking into consideration the results of the public consultation in developing categories.¹⁷ The Commission could also be contacted by any citizen who might wish to disagree with a given ranking during this initial process, or on an ongoing basis thereafter.

The revised list of 709 condition-treatment pairs ranked in order of priority was released in February 1991. Detailed cost estimates for all the pairs were made, to allow the legislature to draw a line at what procedures it would pay for in the new system. This line was drawn at number 587; procedures under that pair would not be covered by public insurance, though private insurance was expected to get into the market to provide procedures and services not covered by the state. Under the legislation, the list of covered services is to be reviewed every two years; both where the line is drawn and the position of particular condition-treatment pairs can be changed in this review.

PROPOSED SYSTEM

List of Covered Procedures

As noted above, the original draft list emphasized costs and benefits, while the second draft emphasized need and medical efficacy. The 709 condition-treatment pairs were divided into 17 categories (such as treatment of "acute fatal conditions, with full recovery," "acute fatal conditions, without full recovery," "acute nonfatal, return to previous health," "chronic fatal, improves life span and quality of life," maternity care, comfort care, and preventive care). These were in turn described as "essential"

(for example, treating fatal conditions and providing preventive care, comfort care, and reproductive services, so important to both society and the individual), "very important," and "valuable to certain individuals." More detailed lists describing the way the pairs were organized are attached as an appendix. It should also be noted that all diagnostic services are covered; Canadian experience suggests that these services can be a significant source of increased costs.¹⁸

Of 366 services described as "essential," eight are not covered, including liver transplant for alcoholic cirrhosis of the liver. Fifty-one of the 275 "very important" services are not covered, including medical therapies for chronic prostatitis and cystitis and breast reconstruction after mastectomy. Five of the 68 services "valuable to certain individuals" are covered.¹⁹

People Covered

Poor People

As noted above, many poor people do not have access to health insurance under the American system. However, under the Oregon proposal, all people under the poverty line would be covered under Medicaid, whether they are receiving AFDC (social assistance) or not, and all employed people would be covered by their employers (see below).

"Uninsurable" People

Senate Bill 534 establishes a high-risk pool for people who have been refused coverage by private insurers, usually because of a "pre-existing condition." This would also respond to some of the problems faced by small businesses in the U.S. Under the present system, their risk is spread among the small pool of one set of employees; as a result, one person with high-risk health problems can make a small business, in effect, uninsurable.

Play or Pay

Finally, the state takes a carrot and stick approach to mandating employer-provided health insurance, giving businesses tax incentives to insure their employees in the early stages of the plan, and forcing them to do so later. Senate Bill 935 requires all employers to provide at least the benefit package provided by the state to all permanent employees and their families. This is expected to cover 300,000 people. Employers are given enriched tax credits if they insure their employees early with the high-risk pool mentioned above; the credits are then gradually phased out. Employers who do not insure their employees would then have to make monthly payments into the pool, which will then cover their employees.

With the refusal of a federal waiver in August (see below), this approach to state-mandated employer-provided health insurance seemed to be dead. It has not proved particularly successful in most other American states,²⁰ probably because existing health insurance is simply too expensive for small employers who cannot negotiate with insurance companies from a position of strength. The Oregon proposal, which gives small employers access to a wider risk pool and provides some global cost control, is influenced by the only successful example of a play or pay system, in Hawaii. In Massachusetts, on the other hand, where a highly publicized plan was legislated, implementation is slowing, and the law itself may be repealed.²¹

Managed Care

On a practical level, this may be the Achilles heel of the plan or similar future proposals. In order to maintain control over costs, it was anticipated that newly insured people under the plan would be enrolled in Health Maintenance Organizations (HMO) and a "primary care case manager program." Oregon has a tradition of fairly good coverage by HMOs, prepaid plans in which each enrolled person pays a given amount of money for all medical care. The case manager program would have contracted with physicians and nurse practitioners to provide all primary care on a

fee-for-service basis, to make referrals for specialist care and to monitor inpatient care for Medicaid clients.²²

The federal Office of Technology Assessment was asked to assess the Oregon proposal, and seemed doubtful that managed care could be implemented as rapidly as the state believed.²³ Also, more fee-for-service care could lead to higher costs; for example, "upcoding" (describing procedures so that they would be covered) would distort the predictions of the program's actuaries.

One of the most disturbing aspects of the proposal would become more relevant in this situation: the law has no definition of basic services, no procedure for detailing the minimum acceptable point within the list of the 709 C-T pairs where the line of covered services must be drawn. With unexpectedly high costs, that line could be drawn much higher than number 587 on the list. In that case many poorer people, especially women and children, would be refused medically necessary and effective services that they receive under the current system.²⁴

SUPPORTERS

Hospitals and Other Providers

Surprisingly enough, given the stiff opposition of American health providers to national health insurance, Oregon providers have been quite supportive of the bill. This was the case even before the state agreed in April 1990 to pay the costs of services as determined by an independent actuary.²⁵ Doctors and hospitals serving low-income Oregonians are particularly familiar with the injustices of the current system; like doctors in Canada, they may also find it financially advantageous to get payments for all their patients even if, in Oregon, they will not be paid for all procedures. The state bill also offers liability protection for doctors who refuse to perform an uncovered procedure. Finally, providers had major input into the development of the plan. Almost 70% of the people who attended the meetings as part of the public consultation process were mental health or health care providers.²⁶

Large Businesses

Private health insurance is a major cost for those employers who provide it to their employees; large businesses are particularly interested in the managed care and limited number of services provided under the Oregon plan. Small employers, on the other hand, who are being forced into a system where they may pay very high administrative costs, oppose the plan.²⁷ However, the state has made serious efforts to control costs for small employers in its play or pay legislation.

Application of Medical Ethics/Cost-Benefit Analyses

Political scientists and professional ethicists tend to see the Oregon process as a model of American ideals of policy making; non-Americans may see it as exemplary of both the virtues and the vices of the American system. The openness of the process is remarkable, especially in a technical field where expertise can intimidate ordinary people. While the public meetings clearly were dominated by providers, the telephone survey on state-wide values, and the remarkable willingness of the Commission to explain how and why they arrived at the ultimate list of procedures can be said to represent public opinion on these issues, to the extent that it is knowable. However, the groups not heard from - women on AFDC, the poor, minorities - are the people who are going to be directly and immediately affected. It is not clear from the record that their views on the proposed changes, as opposed to those of Oregonians generally, received the weight they deserve in debate on the changes.

OPPONENTS

Advocates for Women and Children

One of the most convincing arguments against the Oregon plan is that it would remove coverage of some services from some poor women and children to give health care to other poor people. Under the existing categorical system, poor children under seven, pregnant women and women receiving AFDC are covered by Medicaid, but

single people and the working poor are not. This dilemma illustrates the double, and perhaps conflicting bases of the plan: it is intended both to insure the uninsured and to pay for the most effective services. However, in pursuing the latter goal, it removes some procedures that can help particular individuals who would receive them under the current system if they fit into the covered categories. On the other hand, at present, uninsured individuals would not receive any services at all, except on the basis of charity or emergency. Making the poor in Oregon bear the consequences of this dilemma, while people with private insurance still have access to all the resources of the American system, is seen as an unacceptable solution to the problem of the uninsured.

Pro-Life Organizations

One of the services covered as a high priority in Oregon is abortion, which of course raised the opposition of anti-abortion forces in the state. However, their arguments against the plan have focused on other issues, a strategy which may reflect the generally pro-choice political climate in the state. The Conference of Catholic Bishops highlighted the coverage of abortions, but also mentioned their concerns about rationing among the poor, the lack of a guaranteed level of health care, the strength of providers within the system compared to consumers, and the use of perceived quality of life, rather than a commitment to maintaining life itself, in developing the list.²⁸

Organizations for Disabled People

For these organizations, the emphasis on quality of life is the central problem with the list as it was developed. The telephone survey of Oregonians tried to assess "values," but representatives of disabled people argue that the able-bodied population tends to systematically underestimate the quality of life of the disabled. They also argue that managed care, one of the major components of the plan, is geared to providing acute-care services rather than coping with chronic health problems.²⁹

Other

One argument against the proposal is that there is enough waste and inappropriate spending elsewhere in the federal budget that could be redirected to a national publicly-insured health care system for all Americans. This would be a more appropriate redirection of resources than depriving very poor people of certain procedures so that other poor people can get some services.³⁰ A more specific variant is that there is substantial waste in the American health system (Canada's slower adoption of high-technology tools, such as magnetic resonance imaging, is usually noted with approval in this context), which should be redirected to covering more people. Both these solutions would require substantial political will to implement. This will may be developed by the health care task force chaired by Hillary Rodham Clinton. On the other hand, the granting of Oregon's waiver may indicate that the new administration is dubious about the political benefits of implementing a Canadian system. It may not be entirely coincidental that "managed care," the major policy alternative to single-payer systems like ours, would be easy to integrate with Oregon's proposals.³¹

REFUSAL OF FEDERAL WAIVER

ADA Concerns

One of the most innovative acts of the Bush administration has been the passage of the Americans with Disabilities Act (ADA). This law, which came into effect in 1992, has severe sanctions for individuals and collective entities (such as the government or employers) who prevent the integration of disabled people into mainstream American society. Disabled people, most obviously the terminally ill, would be denied some "curative" treatments under the Oregon proposal (palliative care for the terminally ill would be provided, including hospice care, which is not currently covered under Medicaid). Also, during the ranking procedure, a "tiebreaker" assessment was used, such that when procedures were ranked equally, the one that eliminated all symptoms of illness or disability was preferred.³² However, the ADA says that disabled people must have equal access to all government services, including health care. A legal

opinion from the White House argued that the Oregon plan violates the ADA. It was announced that this was the reason the President refused the waiver the state needed to redistribute its Medicaid funds according to its plan.³³

Political Context

One of the barriers faced by the proposal was, as so often in the American system, sheer inertia. Neither the people who will lose services nor the people who will gain them are particularly powerful interest groups, with the possible exception of disabled people, and this group is covered under the existing system. Within the policy making process, the plan has bipartisan support but also bipartisan opposition in the legislatures, both federal and state. These factors worked to support the status quo.

When he refused the waiver, President Bush was trailing in the opinion polls, and was vulnerable to the charge that his government had done little on the issue of health insurance. This controversial plan distracted from his own proposals on health care - essentially a tax credit to purchase private insurance. Interestingly enough, the new Vice-President, Albert Gore, was one of the major opponents of the Oregon proposals in Washington.³⁴

Granting of Waiver

In spite of this, the new administration decided in March 1993 to grant the necessary Medicaid waiver, with some conditions responding to complaints from disability groups. Health and Human Services Secretary Donna Shalala announced on March 19 that the waiver would be granted, and would run for five years (and presumably then evaluated and granted again or refused). At the same time, she announced 29 conditions on the waiver. These address some of the concerns of disabled groups about the rankings of procedures, by ensuring that treatments that were ranked lower as a result of the "tiebreaker" process (because they do not completely eliminate symptoms of illness or disability) would be recalculated without such a condition. The state also has to consider whether treatment for infertility, a disability, should be

covered, and must set up a telephone line and appeal procedure to allow providers to argue for providing treatments not in the "basic package."³⁵ The conditions also commit the state to providing this basic package of 568 condition-treatment pairs for the five years of the project. Any changes to this list ("drawing the line" higher than 569 on the list of condition-treatment pairs) can only be done with the approval of the federal Department.³⁶

One hurdle remains. Since the 1989 passage of the state legislation, the personnel of the Oregon legislature has changed substantially. As noted above, the state has a budget shortfall, and would need to dedicate an additional \$116 million in its 1993 to 1995 budget plans to fund the health project. Nonetheless, the plan has the support of the new Senate President, and at least some new members of the legislature. It is suggested that funding may come from a new tax, either on health care providers or on beer, wine and/or cigarettes.³⁷ If the money is forthcoming, currently uninsured people eligible for the expanded Medicaid plan will be able to receive insurance in January 1994.

LESSONS FOR CANADA

Public Consultations

It seems clear that the public meeting process in Oregon was dominated by health providers, and results should be examined in the light of that fact. Of more than 1,000 people attending the meetings, over 70% were health and mental health providers; this was clearly one of the reasons the Commission did the random telephone survey. However, the effort to bring the public into serious considerations of matters which in the past have taken place behind the curtain of professional discretion and resource constraints deserves praise. The Commission's willingness to revise its original list, using substantially different premises, and to have its deliberations publicly debated, also may have lessons for the Canadian system, where discussions among the relevant 'stakeholders' is a much more familiar model of 'consultation.'

Examination of Therapies: Not Who is Covered, but What is Covered

This process is already taking place in Canada, as provincial health plans "de-insure" certain services. At present, however, rather dubious methods for determining which services to remove seem to be the rule: if some provinces don't cover a service, others can safely drop it. As well as offering lessons to Canadians on process, the Oregon approach addresses an important question of substance. General practitioners tend to be the primary gatekeepers in the introduction and implementation of procedures and treatments. However, growing research literature is showing that the effectiveness of many medical procedures routinely used has not been demonstrated and there has been little consistent effort to evaluate new or established procedures or to disseminate the results of such evaluations. At the same time, incentives created by fee-for-service medicine tend to reward treatment over prevention or watchful waiting. Finally, it is difficult for general practitioners to keep up with rapid developments in clinical knowledge. All these factors may make the traditional gatekeeping role too heavy a burden for doctors alone. The Oregon process took a first step towards spreading this responsibility around a larger group of people, and evaluating procedures and care in terms of health outcomes.

Building on Strength

Canadians are fortunate to be facing decisions within the context of a system they are generally happy with and more or less willing to pay for.³⁸ However, costs are rising, and the system is becoming increasingly complicated. Oregon is grappling with the question of who is the gatekeeper to that system, who decides what is "medically necessary," and how to provide those services most effectively to the whole population. Canada need not take the same route to its own answers, but it will need to address the same questions.

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²¹ Robert J. Blendon et al., "The Uninsured and the Debate over the Repeal of the Massachusetts Universal Health Care Law," *Journal of the American Medical Association* 267:8 (26 February 1992): 1116-1117.

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²³ United States, General Accounting Office, Report to the Chairman, Subcommittee on Health and the Environment, Committee on Energy and Commerce, House of Representatives, *Medicaid: Oregon's Managed Care Program and Implications for Expansion* (Washington: The Office, 1992), pp. 3-5.

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²⁶ *Ibid.*, p. 21.

²⁷ Because of their lack of power, as small fragmented buyers of services, small businesses bear the brunt of costs in the American system. For a useful discussion of how this process operates, see Uwe Reinhardt, "Commentary: Breaking American Health Policy Gridlock," *Health Affairs* 10:2 (Summer 1991): 97-103.

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³⁰ Amitai Etzioni, "Commentary: Health Care Rationing: A Critical Perspective," *Health Affairs* 10:1 (Summer 1991): 88-95.

³¹ Managed care is the proposal of Alain Enthoven, an American academic. Under it, a minimum package of health care benefits would be established; the government would limit employers' or employees' tax exemption to the level of the minimum package; individuals and employers would then have an incentive to shop for the cheapest package that could meet their needs ("Say aargh for reform," *The Economist* (6 February 1993): 25-26.

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